January 6, 2006 letter regarding Status of Recommendations Made in the November 2004 Merrick J. Bobb Special Report

December 16, 2005 letter regarding Status of Comprehensive Jail Security Audit

3-28 12-605

County of Los Angeles
Sheriff's Department Headquarters
4700 Ramona Boulevard
Monterey Park, California 91754-2169

LEROY D. BACA, SHERIFF

December 16, 2005

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

STATUS OF COMPREHENSIVE JAIL SECURITY AUDIT

On December 6, 2005, your Board requested that the Los Angeles County Sheriff's Department (Department) provide a report on the status of our efforts to obtain a comprehensive jail security audit as recommended in Special Counsel Merrick J. Bobb's November 2004 report. The report recommended a comprehensive audit based primarily on observed security lapses at Men's Central Jail (MCJ), which were attributed to inadequate staffing. As the report states, "effective security, of course, is dependent on adequate security staffing."

Aside from MCJ, the Department operates another eight jail facilities that house an additional 13,000 inmates. In comparison to other local jails throughout the nation, none are as large as the mammoth Los Angeles County Jail system, and none have the significant disparity in inmate-to-staff ratios. Therefore, security concerns should be addressed throughout the Department's entire custody operation, not just MCJ.

Representatives from our Custody Operations Division have been in contact with a variety of agencies and individuals regarding the undertaking of a comprehensive and system-wide security audit. One such agency is the National Institute of Corrections (NIC). The NIC's State Prison Network provided the names of several individuals who have completed NIC's 36-hour training course and have conducted security audits in the past. These individuals are executives employed with the following systems:

- Florida Department of Corrections;
- South Carolina Department of Corrections;
- Oregon Department of Corrections;
- Colorado Department of Corrections.

Although the NIC would provide training on conducting these audits to our own personnel, it is recommended that an outside firm or consultant complete the task. Based upon the complexity of the audit and its value to the Department and your Board, an independent party should be involved in the process to maintain the integrity of any final report.

To date, the consensus among jail experts and NIC representatives is that the Department, due to its large and highly elaborate jail network, would best be served by producing Request for Information (RFI) or Request for Proposal (RFP) documents for review and comment by prospective consultants. The Department is currently working with one of these experts on identifying guidelines for writing an RFI on the subject. We should have the document posted for review the first week of January 2006 and will begin making contact with prospective consultants, so they may review and comment on it. When the Department reports back to your Board on January 10, 2006, we will brief you on the status of the RFI.

Finally, for its November 2004 Special Report, the Special Counsel utilized the services of Steve J. Martin, a nationally recognized jail policy and procedure consultant, and court appointed administrator who recommended the security audit in the November 2004 Special Report. Mr. Martin, who does not conduct security audits as a practice, provided us with the name of a Texas consulting firm that recently completed a comprehensive security and staffing audit of the Cook County jail system. Mr. Martin also recommended the services and expertise of two members of the NIC's Large Jail Network, who are currently employed as large jail agency executives.

Once several qualified consultants and a funding source are identified, the Department will return to your Board for approval of a contract for services. In the interim, Custody Operations Division and Correctional Services Division executives are currently identifying and selecting Department subject matter experts, to begin the process of internally auditing jail security operations, with the intent of working in conjunction with our Risk Management Bureau and, ultimately, the selected independent consultant.

If you have any questions, please contact Chief Sammy L. Jones, Custody Operations Division, at (213) 893-5001, or Chief Marc L. Klugman, Correctional Services Division, at (213) 893-5017.

Sincerely,

Lee Baca

LEROY D. BACA
SHERIFF

County of Los Angeles
Sheriff's Department Headquarters
4700 Ramona Boulevard
Monterey Park, California 91754-2169

LEROY D. BACA, SHERIFF

January 6, 2006

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

STATUS OF RECOMMENDATIONS MADE IN THE NOVEMBER 2004 MERRICK J. BOBB SPECIAL REPORT

On December 6, 2005, your Board requested that the Sheriff's Department provide a comprehensive report addressing our response to the 21 recommendations made in Merrick Bobb's November 2004 Special Report. We initially responded to the 2004 Special Report on December 30, 2004. Attached is a current update on each recommendation, including a summary of current technology utilized by other law enforcement agencies for monitoring inmate movement. Additionally, an overview of risk management related procedures for our custody operations is included with this report.

Should you have any questions, please contact Chief Marc L. Klugman, Correctional Services Division, at (213) 893-5017 or Chief Sammy L. Jones, Custody Operations Division, at (213) 893-5001.

Sincerely,

LEROY D. BACA
SHERIFF

JANUARY 2006 UPDATE TO THE MERRICK J. BOBB SPECIAL REPORT

COUNTY OF LOS ANGELES - SHERIFF'S DEPARTMENT

The purpose of this document is to provide an update to the findings and recommendations of the November 2004, *Los Angeles County Jail - A Review Following Five Inmate Homicides,* prepared by Special Counsel Merrick J. Bobb and staff. The Department's original response to the report was provided in December 2004. The following paragraphs are the January 2006 updates and they address each of the Special Counsel's recommendations.

I. Classification and Housing

A. Create a centralized classification and housing bureau.

It has long been held by the Department that the individual jail facilities were best suited to determine housing assignments for their inmates. The Department's jail managers have since revisited this issue and are actively considering this recommendation from the Special Report.

The centralizing of individual inmate housing assignments, through the Inmate Reception Center (IRC), would allow us to better utilize all housing areas and expand capabilities throughout the jail system instead of limiting resources to each unit. Centralization would allow special handle and classification issues to be addressed in the manner desired by the respective division chiefs and uniformly implemented throughout their divisions.

The classification and housing bureau would remain under the command of the IRC Captain. Classification currently has limited management of inmate housing, basically determining the appropriate facility for the inmate, and then allowing each facility to determine the bunk location. Therefore, a separate bureau as recommended in the Special Report is not necessary at this time. However, we will reconsider this issue in the future, as the Department's current classification program expands.

We are currently exploring ways to implement security level housing throughout Custody Operations Division with our existing technology. Custody Support Services, Jail Automation, and Classification are involved in a joint project to assign security levels to individual housing locations. This will begin the process of centralizing housing assignments at Classification.

Several steps have already been taken toward implementation of centralized housing assignments. A draft matrix assigning a security level to virtually every inmate bed has been completed and was recently presented to all custody facility managers for review and comment. However, the County Jail's operation is so vast and complex that issues of inmate transportation to the courts, demographics, segregation of rival gangs, availability of bed space, a fluctuating inmate population, and unpredicted events such as housing closures due to maintenance or major disturbances must be addressed before a baseline housing matrix for all of Custody Division can be finalized.

Additionally, the Department is currently reviewing the feasibility of housing all gang members charged with murder in one or two-man cells. The Special Handle policy is currently being modified to identify every special handling designation and eliminate unofficial designations. The Custody Automation Lieutenant is researching software companies to locate products that may suit our needs. The Inmate Population Management committee was created to identify all the needs of inmates and facilities, and to help ensure procedural changes will fit our requirements.

B. Create a comprehensive classification plan.

As stated in the Department's 2004 response, a comprehensive classification plan already exists. As the centralization of housing assignments expands, the classification plan will further develop.

C. Create a functional operations manual governing classification and housing assignments.

A manual regarding classification exists, as stated in the Department's December 2004 response. The Custody Division Manual currently provides policy regarding inmate housing, which is readily accessible from all Department computers. Expansion of the policies would occur as the Department becomes capable of centralizing housing assignments. Additionally, the Department is currently developing a classification training curriculum, for use by line custody facility personnel, as we recognized the importance of staff having a basic understanding of classification procedures when processing inmates in the housing areas.

D. Maintain distinct housing for separate security levels.

Refer to Section I, Subsections B and E.

E. Establish and enforce custody boundaries for separate security levels.

We currently use the Northpointe Jail Inmate Classification System (JICS) to classify our inmate population. The Northpointe system is a valuable tool that we will now integrate with software that we currently own and acquired from Syscon Justice Systems, Inc. The integration will prove to be an efficient and a cost effective way to not only accurately classify inmates, but also utilize a housing module that will identify the best cell to place an inmate based on his/her security level and special handling needs. Based on the fact that the two systems are now in place, we would only require minimal reconfiguration of our software from Syscon's staff. This could be done in early 2006 at a minimal cost.

However, a program of this nature would require additional personnel and supervisors. Although the technology should be able to resolve most issues, additional funding would be necessary to provide each jail facility with an IRC Classification employee assigned for its housing issues. These employees would ensure constant and open communication between the unit and Classification; perform security level re-classes; and maintain the facility housing matrix.

F. Make individualized housing assignment determinations.

Refer to Section I, Subsections B and E.

II. Security Administration

A. Inmate-to-staff ratios.

1. Increase staffing levels.

As referenced in the Department's December 2004 response, staffing Men's Central Jail (MCJ) at a recommended ratio of one employee for every four inmates (1:4) is cost prohibitive. However, it is critical to note that the Special Counsel's November 2004 report stated MCJ's ratio was 1:10 and, while this figure was accurate, it was a broad representation of staffing as opposed to a more precise look at how many employees are directly supervising inmates at any given time. In other words, the 1:10 ratio is based upon MCJ's total personnel complement, including administrative and support staff, spread over a 24-hour period, 365 days a year. Additionally, because some inmates require greater security than

others we must utilize an unequal, but necessary, staffing matrix to meet those needs.

Therefore, when excluding administrative and support personnel, and dissecting the MCJ deployment strictly into on-duty line employees, a more ominous picture is revealed. MCJ's employee to inmate ratio ranges from Day shift having the highest staffing level, at 1:33, to EM (graveyard) shift being the lowest, at 1:62. When further parsed into the direct supervision of inmates, the ratios in the 50 housing areas range from 1:14 in the high security modules all the way down to 1:320 in some dormitories. The significant challenges facing the MCJ staff were best summed up in the Special Counsel's November 2004 report (page 3):

> *There are no jails in any city or county in the nation that house in one building the equivalent number of inmates as does MCJ. The jail is antiquainted, difficult to adequately secure, and requires staffing levels that far exceed the current staff-to-inmate ratios. To do it right, there should be a ratio of no more than four, or, at worst, five or six inmates to one member of the staff.*

On a positive note, Century Regional Detention Facility (CRDF) is slated to be reopened as a woman's jail in March 2006. This will permit the incremental occupation of Twin Towers Correctional Facility's Tower II, with high security level male inmates beginning in April 2006. The Department will gain some desperately needed high security cell space, but still faces unprecedented challenges in filling personnel vacancies as stated in the December 5, 2005, letter to your Board.

In an effort to increase the staffing levels of the Department, Personnel Administration's Recruitment Unit has made significant strides in contacting potential applicants and has created several innovative recruitment programs. To accomplish heightened hiring goals, the Department now employs 2 sergeants, 16 deputy sheriffs, and 3 custody assistants in the Recruitment Unit. The Background Unit, which averages 500 completed investigations a month, is staffed with 6 sergeants, 48 deputy sheriffs, 11 professional staff, and 8 part-time retired personnel.

Since January 2005, the Recruitment Unit has attended over 400 events and contacted more than 18,000 potential applicants. The Department has also increased out-of-state recruitment and testing efforts. From July through November 2005, 78 out-of-state applicants were tested. In Fiscal

Year 2005-06, the Department is expected to attend over 450 local events and contact 20,000 potential applicants.

To provide more immediate relief to the custody staffing situation, the Department is currently researching the feasibility of having special transfer periods for those Deputy Sheriffs specifically interested in returning to Custody Operations or Correctional Services Divisions from their current unit of assignment.

Finally, before any revised staffing model is considered for MCJ or any other facility, the comprehensive security audit recommended by the Special Counsel must be completed in order to determine how the entire network should be staffed.

B. Inmate Movement

1. Establish and enforce policies governing inmate movement.

Since early 2004, the Department has undertaken a large number of policy and procedural reviews. The primary body responsible for these reviews was the Inmate Movement Prisoner Accountability Classification Taskforce (IMPACT). The following changes were made to the Custody Division Manual.

Inmate Special Handling:

a. Discontinue the High Bail (K-6 Green Band), Two/Three Striker and 187 P.C., Murder (Purple Wristband) special handles;
b. Change K-6 to Special Needs Inmate, e.g., blind, deaf or developmentally disabled;
c. Change the "T" special handling code from "Transportation" to "Contempt of Court";
d. Made a special handling pamphlet for distribution to Department personnel within Custody Division.

Inmate Identification Cards:

a. Inmate identification was enhanced by issuing each inmate an identification card that is color coded to match the

wristband and contains the inmate's photograph, name, booking number, and special handling code(s).

Uniforms:

a. Adopted policy designating clothing colors to assist in inmate identification.

Miscellaneous Policy Changes:

a. Inmate worker selection process;
b. Court-released inmates housing notification;
c. Wheel-chaired inmates transportation to court;
d. Pre-arraigned inmates identification.

2. Radio Frequency Identification (RFID) technology.

Currently, RFID is the most cutting-edge inmate movement technology utilized in the custody environment. It is best described as a real time inmate tracking system. Some experts have referred to it as "LoJack for inmates." There are three types of RFID systems, the most advanced utilizing what are known as "active tags." In essence, a tag is a microchip attached to an antenna, which is packaged in such a way so that it can be applied to an object or person in order to monitor movement. Active tags are capable of accurately and continuously tracking an inmate's movement from long distances to within a three-foot radius. Agencies that have installed RFID technology have experienced as much as a 65 percent reduction in inmate versus inmate assaults. Two such prison facilities that currently utilize active tags are the Logan (Illinois) Correctional Center and the California Department of Corrections and Rehabilitation's Calipatria State Prison.

One major drawback with RFID technology is that it is very expensive. It is a potential pilot project at Pitchess Detention Center - East Facility. The cost of this pilot project would be over $1.6 million, including a necessary independent evaluation and review. The expansion of RFID technology to every Department custody facility will be an estimated onetime cost of $18-20 million and $500,000 to $600,000 per year for ongoing maintenance and supplies.

Your Board has been very supportive of the Department's various custody technology needs, recently appropriating $2.5 million for several enhancements, such as (1) security cameras and monitors in the MCJ Hospital, (2) Lexan security barriers in the MCJ Attorney Room, and (3) handheld wireless bar code readers for Title 15 security checks. And while simply employing technology is not a panacea for all of the County Jail's security ills, it can have a significant positive impact on some parts of the operation, with RFID appearing to be a highly viable option. Therefore, before beginning the East Facility pilot project, this Department and your Board must determine the County's long-term desire to implement RFID technology in the jail system.

3. Fixed security cameras.

The Closed Circuit Television (CCTV) installation at Pitchess Detention Center, East Facility became fully operational on August 17, 2005. The cameras digitally record activity throughout the facility 24 hours per day, 7 days per week, with an estimated archiving capacity of 54 days. The system has already proven invaluable. In just the first few weeks of operation, the system recorded two incidents wherein the videos were used as evidence by investigators to file charges with the District Attorney's Office. Because this program has been very well received, we are currently evaluating the feasibility of expanding it to other custody facilities, such as the use of fisheye cameras at MCJ. However, it must be understood that while this is a valuable tool after the fact, and it may prevent some criminal activity by virtue of its existence, CCTV's ability to stop all inmate assaults from occurring remains dubious at best.

4. Comprehensive security audit.

The November 2004 Special Report recommended a comprehensive audit based primarily on observed security lapses at MCJ, which were attributed to inadequate staffing. As the report states, "effective security, of course, is dependent on adequate security staffing."

Aside from MCJ, the Department operates another eight jail facilities that house an additional 13,000 inmates. In comparison to other local jails throughout the nation, none are as large as the mammoth Los Angeles County Jail system, and none have the significant disparity in staff to inmate ratios. Therefore, security concerns should be addressed throughout the Department's entire custody operation, not just MCJ.

Representatives from our Custody Operations Division have been in contact with a variety of agencies and individuals regarding the undertaking of a comprehensive and system-wide security audit. One such agency is the National Institute of Corrections (NIC). The NIC's State Prison Network provided the names of several individuals who have completed NIC's 36-hour training course and have conducted security audits in the past. These individuals are executives employed with the following systems:

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To date, the consensus among jail experts and NIC representatives is that the Department, due to its large and highly elaborate jail network, would best be served by producing Request for Information (RFI) or Request for Proposal (RFP) documents for review and comment by prospective consultants. As such, the Department is posting an RFI on its and the County's official web sites the second week of January 2006. We will keep your Board apprised on the status of any prospective consultants.

Finally, for its November 2004 Special Report, the Special Counsel utilized the services of Steve J. Martin, a nationally recognized jail policy and procedure consultant, and court appointed administrator who recommended the security audit in the Special Report. Mr. Martin, who does not conduct security audits as a practice, provided us with the name of a Texas consulting firm that recently completed a comprehensive security and staffing audit of the Cook County, Illinois jail system. Mr. Martin also recommended the services and expertise of two members of the NIC's Large Jail Network, who are currently employed as large jail agency executives.

Once several qualified consultants and a funding source are identified, the Department will return to your Board for approval of a contract for

services. In the interim, Custody Operations Division and Correctional Services Division executives have formed a team of Department subject matter experts, to begin the process of internally auditing jail security operations, with the intent of working in conjunction with our Risk Management Bureau and, ultimately, the selected independent consultant.

C. Title 15 Safety Checks

1. Fixed surveillance cameras in IRC holding cells.

Refer to "Fixed security cameras," Section II, Subsection B, Item 3.

2. Safety check accountability.

Sergeants are continually briefed on the importance of safety check accountability and the need to inspect their subordinates' work product.

Additionally, when the Title 15 Compliance Officer Program was initiated at Men's Central Jail, handheld wireless scanners were purchased through funding approved by your Board. Security checks and related activities, such as inmate showers, and bedding and clothing exchanges, are now time stamped to provide greater and more accurate accountability.

3. Safety check quality.

This recommendation was addressed in 2004. Men's Central Jail Unit Orders state that personnel shall conduct thorough safety and security checks and take all necessary steps to effectively complete these checks. They are now clearly documented in the Daily Activity Logs, assigned to each module/dorm.

4. Supervisory presence.

Sergeants are continually briefed on the importance of accountability for their subordinates, the need to make their presence known, and that they are responsible for their "personal acts and omissions and when reasonable and appropriate, the acts and omissions of their subordinates," consistent with the Department's Manual of Policy and Procedures.

5. Increase custody staff presence on the rows.

   In July 2004, the Department implemented the Title 15 Compliance Officer Program. Designated staff members were assigned throughout Custody Operations Division to ensure respective jail facilities fully comply with Title 15, California Code of Regulations, with an emphasis on the mandated hourly inmate safety checks. Since implementation, the program has been continuously monitored for effectiveness and has been highly successful. From August 2004 through October 2005, there were 232 reported interventions in potentially serious incidents such as, but not limited to, attempted suicides, jailhouse weapons offenses, assaults and major disturbances.

D. Inmate workers.

1. Create and enforce a uniform policy for inmate worker selection.

   This recommendation was addressed in 2004. As a result of the inmate homicides, we have created the Inmate Movement Prisoner Accountability Classification Task Force (IMPACT). The IMPACT committee's mission is to review classification and housing issues in an effort to improve policies and procedures. On November 4, 2004, we implemented Custody Division Manual (CDM) Directive 04-002, Inmate Uniforms. This policy will update CDM section 5-01/015.00, regarding inmate uniforms. This policy simplifies the color combinations for various inmate classifications or categories.

2. Classification and housing bureau should be responsible for inmate worker eligibility determinations.

   In 2004, the IMPACT committee made several recommendations for the selection requirements of inmate workers; this revision also includes housing and inmate worker selection (CDM Section 5-01/025.00). The concerned CDM section, Housing Area Inmate Workers, was updated to establish inmate worker selection parameters, including a requirement for final approval from the concerned sergeant before an inmate is allowed to work.

E. Housing area searches.

1. Continued emphasis on searches.

The Department's facilities continue to strongly emphasize the need for systematic searches and, upon approval of funding by your Board, the Title 15 Compliance Officer Program was implemented and has been a very successful intervention tool (refer to Section II, Subsection C, Item 5).

F. Inmate-on-inmate violence.

1. Track and monitor statistics.

The inmate versus inmate module of our Facility Automated Statistical Tracking (FAST) system has been operational for 18 months. The database is capable of producing statistics based upon a variety of variables including, but not limited to, facility, day of the week and type of location. For example, throughout the jail system from January 1 through December 11, 2005, there have been a total 2,563 inmate assaults and the most prevalent day for an assault is Wednesday. These reports are available to each facility. Additionally, during the December 8, 2005, Custody Operations Division executive staff meeting, management was briefed on the functionality of the FAST system and the importance of utilizing it as a tool for monitoring inmate activities within their respective facilities.

2. Increase staff presence.

As previously mentioned, the Department plans on opening CRDF in March 2006. Additionally, the Title 15 Compliance Officer Program has been highly successful with increasing employee presence and preventing significant jailhouse incidents. However, there continues to be many staffing difficulties. For example, the Department has done an extraordinary job of recruiting and hiring at all positions, with particular attention to the Deputy Sheriff Generalist classification. Through November 2005, it has hired 477 Deputy Sheriffs. Unfortunately, the Department also lost 448 sworn personnel for a myriad of reasons, including retirements, service connected disabilities, and 118 lateral resignations to other law enforcement agencies, thus resulting in a year-to-date net gain of only 29 Deputy Sheriffs. Therefore, while the Department has experienced great success with its hiring campaign, it faced a huge vacancy factor at the time the program was implemented and, as such, will face continued challenges in the foreseeable future.

CUSTODY RISK MANAGEMENT PROCEDURES

In *The Los Angeles County Sheriff's Department 6th Semiannual Report,* published in September 1996, the Special Counsel recommended "There should be a separate Custody Risk Management Unit created within the Professional Standards and Training Division [now referred to as 'Leadership and Training Division'] devoted to custody liability issues. As the current Custody Planning and Research Unit is phased out, appropriate personnel from it should be transferred to it" (page 20). This recommendation was borne out of the Special Counsel's concern over the availability and reliability of inmate activity data, and the Department's ability to address custody liability issues.

In 1997, in response to the recommendation, the Department significantly expanded the former Custody Planning and Research Unit into the present Custody Support Services Unit (CSS). Due to the need for staff with significant jail experience, CSS is currently assigned under the dual umbrella of the Custody Operations and Correctional Services Divisions, and is divided into three teams: Data Analysis, Standards and Compliance, and Risk Analysis.

The Data Analysis Team collects volumes of information from available sources, such as records of inmate assaults, discipline, criminal activity, etc., and ensures data integrity. The Team also analyzes the information in order to determine trends that may increase liability, so corrective action may be taken. The Standards and Compliance Team is responsible for ensuring that custody facilities are in compliance with Department and division policies and procedures, as well as any state and federal mandates. The Risk Analysis Team works very closely with the Department's Custody Training Unit, Legal Advisory Unit, Risk Management Bureau and Medical Services Bureau, in order to identify and mitigate custody liability issues, and take any necessary corrective action.

The three CSS teams complete a myriad of risk management oriented assignments including (1) review and analysis of all critical inmate incidents, such as escapes, major disturbances, and inmate deaths; (2) performing formal custody facility inspections in 26 areas including security and fire-life safety; (3) revising divisional policies and procedures when appropriate; and (4) responding to inspections, reports and inquiries from entities such as the United States Department of Justice, the State Corrections Standards Authority, County Health and Fire Departments, and the American Civil Liberties Union. In April 1997, the Special Counsel acknowledged the creation of CSS and its primary mission of being a "risk management unit" in the Department's *7th Semiannual Report* (pages 30-31).

Since the formation of CSS, several custody policies and procedures have been implemented on (1) the accurate reporting of statistics; (2) data integrity audits at all

facilities; (3) analysis of critical inmate incidents, including immediate CSS response to the scenes under specified circumstances; (4) recommending and ensuring compliance with any directed corrective action; and (5) reducing liability exposure through jail inspections and other proactive means.

For example, in the case of the November 16, 2005, murder of Inmate Chadwick Cochran, a sergeant and deputy from the CSS Risk Analysis Team immediately responded to the scene of the incident, conducting a review of all applicable activity logs and forming a time line as to what occurred.

This Team is also responsible for ensuring the comprehensive Inmate Death Reporting and Review Process policy (attached) is strictly followed. Every in-custody death, regardless of the cause, will have a formal review, which falls into one of three categories:

Level I Review:	Inmate deaths attributed to natural causes, occurring in a hospital or medical facility.
Level II Review:	Inmate deaths including suicides, homicides, and some natural cause deaths with unusual or extenuating circumstances. Mr. Cochran's death will be a Level II Review.
Level III Review:	All inmate deaths that occur at the hands of a deputy or other custody personnel, or as designated by the Division Chief.

Death Reviews are handled exclusive of personnel and criminal investigations, and specifically address all remaining facets of the incident, such as policy and procedure concerns; training issues; security deficiencies; medical and/or mental health care quality assurance, and a risk review by the Department Legal Advisor. Upon completion of the personnel and/or criminal investigations, a Death Review is scheduled with management and the appropriate subject matter experts, with the Review level determining the required attendees.

Once the Death Review is heard by the custody executives, they will make a determination of what, if any, action is necessary. Additionally, a comprehensive dossier, complete with written analyses by the concerned policy, training and medical experts and copies of all related activity logs and reports, is assembled outlining those concerns that came to light during the Death Review. CSS is responsible for ensuring any follow-up action ordered by Department executives.

CUSTODY RISK MANAGEMENT PROCEDURES

As referenced earlier in this report, the Custody Operations and Correctional Services Division executives have enjoined a team of Department subject matter experts, to begin the process of internally auditing jail security operations with the intent of working in conjunction with our Risk Management Bureau (RMB) and, ultimately, the selected independent consultant. While the CSS Standards and Compliance Team is currently responsible for conducting annual security inspections at every facility, staffing limitations have restricted them to a more cursory review of the operations.

Therefore, based upon their expertise, CSS staff will be spearheading the preliminary internal security audit, with experienced custody deputies and supervisors assigned, as needed, to assist with the process. Due to their more global perspective, RMB has been requested to participate in the security audits as their past experience in the civil litigation and corrective action arena may help bolster any security deficiency findings.

4-10/050.00 INMATE DEATH - REPORTING AND REVIEW PROCESS

Scope of The Policy

The Inmate Death - Reporting and Review Process policy applies to all inmate deaths that occur in Custody Division jail facilities, or deaths of inmates who are under the purview of the Custody Division, in Court Services Division Lock-up's, Court Services Transportation vehicles, and the Field Operations Regions' station jails.

Community Based Alternatives to Custody (CBAC)

This policy also applies to inmates enrolled in the Community Based Alternatives to Custody (CBAC) program; however, CBAC inmate deaths shall not be included in the "in-custody" inmate death statistical totals. (See Custody Support Services' Staff Responsibility section for procedures pertaining to CBAC inmate deaths.)

This policy does not apply to prisoner deaths occurring under the jurisdiction of field operations.

Unit Watch Commander Responsibilities

Telephonic Notifications

In the event of an inmate/prisoner death in a Los Angeles County jail, the watch commander of the unit, at the time of the inmate death, shall be responsible for making a telephonic notification of the death and all pertinent information, as soon as possible, to the following:

- Division Chief, when death occurs at the hands of another inmate or a staff member(s),
- Area and/or Duty Commander,
- Unit Commander,
- Homicide Bureau,
- Internal Affairs Bureau on-call lieutenant (via Sheriff's Headquarters Bureau Media Section after hours), in cases of death following contact with a Department member, and other circumstances as detailed in the Department Manual of Policy and Procedures, section 5-09/430.00, "Use of Force Reporting and Review Procedures,"
- Inmate Reception Center watch deputy - Custody Division Log,
- Sheriff's Headquarters Bureau Media Section - Department Operations Log,
- Sheriff's Medical Services 24 hr. Nursing Desk, Medical Services Building,

- Risk Management Bureau - Civil Litigation Unit,
- Custody Support Services Unit or the on-call supervisor/manager (after hours).

Requirements for telephonic notifications to Custody Support Services are as follows:

- Level I inmate death - appears to be a natural cause death, and has no unusual circumstances, does not require telephonic notification. An E-mail notification, including all pertinent information is sufficient,
- Level II inmate death - an inmate death with unusual circumstances, such as a suicide, homicide, or when significant issues are present, always requires a telephonic notification,
- Level III inmate death - an inmate death at the hands of an employee, always requires a telephonic notification.

Pertinent information shall include, but is not limited to, the following:

- Name of the deceased,
- Race,
- Age and date of birth,
- Booking number,
- Arrest charge,
- Uniform Report Number (URN) assigned to the inmate death complaint report,
- Custody reference number,
- Facility or location where the death occurred,
- Preliminary cause of death (if known),
- Time pronounced dead,
- Pronounced dead by,
- Any use of force,
- Any unusual circumstances,
- A brief synopsis of the circumstances.

Written Notifications

In addition to making the above telephonic notifications, the concerned watch commander shall promptly prepare and send, by facsimile or electronic mail, the following written documents concerning the inmate death:

- A memorandum to the Division Chief on an Office Correspondence form (SH-AD32A), with a brief statement of facts.

- A Watch Commander's In-Custody Death Reporting Form, to the Custody Support Services' Risk Analysis Unit.

All other reporting procedures pursuant to the Department Manual of Policy and Procedures, section 4-19/010.00, "Person Dead," shall apply.

Inmate Reception Center

Watch Deputy Responsibility

The Inmate Reception Center (IRC) watch deputy shall notify the Head Clerk's Office, Records Section and prepare a Custody Division Operations Log entry of the inmate death.

Head Clerk's Office - Records Section Responsibility

Upon notification of the inmate death, the Head Clerk's Office - Records Section, shall update the Automated Jail Information System (AJIS) computer, and forward the booking record to the State Prison Desk. The State Prison Desk shall reproduce the complete booking record and immediately forward a copy to Custody Support Services for inclusion in the Inmate Death Review.

Custody Support Services' Lieutenant Responsibilities

Upon notification of an inmate death, the Custody Support Services' lieutenant, the unit commander of Medical Services, and the Chief Medical Physician shall schedule a death review as soon as possible after the occurrence to review medical protocol, policy and procedures, training issues, and risk management liability relating to the in-custody death.

The Custody Support Services' lieutenant shall assess the circumstances of the in-custody death and notify the Training Division-Custody lieutenant, or the on-call training representative after hours, wherein a response from the Training Unit representative is deemed warranted.

Custody Support Services' Supervisor Responsibilities

Upon notification of an inmate death, the Custody Support Services' on-call sergeant shall make a determination, based upon the totality of the circumstances, whether an immediate response to the location of the inmate death is necessary. The sergeant shall consider all the circumstances, particularly in the case of:

- Homicide,
- Suicide,
- Inmate death at the hands of another inmate(s),
- Inmate death at the hands of a Deputy and/or other Custody personnel,
- Apparent natural causes death with unusual circumstances.

Inmate deaths by apparent natural causes will not warrant an immediate response by Custody Support Services' personnel.

The Custody Support Services' on-call sergeant shall assign personnel to conduct a review of the in-custody death and prepare a comprehensive report.

Custody Support Services' Staff Responsibilities

Inmate Death Review

Custody Support Services shall collect all related documentation concerning all inmate deaths and prepare a written review. The review shall address issues and make recommendations in an attempt to reduce future risk management liability to the Division and the Department. The review shall include, but not be limited to:

- Witness interviews,
- Training issues,
- Policy and procedure issues,
- Identification of potential medical and mental health issues.

A copy of the death review shall be forwarded to the concerned unit commander for review and response, which shall be reported back to the Division Chief within 30 days on any action taken. The unit commanders' responses shall be filed with the in-custody inmate death review file at Custody Support Services. The Custody Division Legal Advisor shall review and approve all recommendations and unit commander responses.

Community Based Alternatives to Custody (CBAC) Inmate Death Review Procedure

In cases of deaths involving inmates participating in CBAC programs, including Electronic Monitoring, Work Release, and Work Furlough, Custody Support Services' staff shall conduct a preliminary review of the circumstances. All available documentation including police reports, booking records, and an analysis of any Department medical records shall be collected. Findings shall be reported to the Division Chief, in accordance with the Levels of Inmate Death Review and Reporting

section of this policy. In conducting the preliminary review, particular attention shall be paid to the inmate's classification and qualifications to participate in a CBAC program.

The inmate death review briefing (see Levels of Inmate Death Review and Reporting), along with all documentation collected, and any follow-up, as directed by the Division Chief, shall constitute the total CBAC inmate Death Review package. In cases with extenuating circumstances, the full review procedures, as described above under Inmate Death Review section, shall apply.

Facsimile Notification

Within 48 hours following an inmate death, Custody Support Services shall send a facsimile of a Custody Support Services In-Custody Death Reporting Form to the Division Chief and the following entities:

- U.S. Department of Justice,
- CA. Department of Justices,
- Legal Unit,
- American Civil Liberties Union,
- County Counsel,
- Risk Management Bureau,
- Jail Mental Health Services,
- Board of Corrections.*

  *(When the deceased is a juvenile inmate only)

The Custody Support Services' Area Commander, or other Custody Division Commander, shall review and approve the Custody Support Services In-Custody Death Reporting Form, prior to its transmission to the Department of Justice, the ACLU, the County Counsel, the Risk Management Bureau, the Jail Mental Health Services, the Board of Corrections, and the Division Chief.

A copy of the facsimile shall be retained in the Inmate Death Review file at the Custody Support Services Risk Analysis Unit.

Retention of In-Custody Death Records

All Inmate Death Reviews conducted by Custody Support Services, audio and video recordings, documents, memorandums, interviews, and other written administrative documents concerning the inmate death, shall be maintained by Custody Support Services, Risk Analysis Team.

The Medical Services Medical Records section shall retain all medical records relating to in-custody inmate deaths.

All Death Reviews are Attorney-Client privileged, and shall not be released to any non-Department member without the consent of the Division Chief, and the Custody Division Legal Advisor.

All in-custody inmate death records shall be maintained for a period of seven years. After seven years, all in-custody inmate death records will be forwarded to the Sheriff's Records and Identification Bureau for archive retention.

Medical Services' Responsibilities

The Medical Services' Risk Management representative shall conduct a Medical Mortality Review of all inmate deaths. A copy of the written report and findings shall be forwarded to the unit commander of Medical Services. A copy of the Medical Mortality Review shall be forwarded to the Custody Support Services' Risk Analysis Unit, for inclusion in the In-Custody Death Report.

Levels of Inmate Death Review and Reporting

Level I Review & Reporting

A Level I Review is the lowest level review. A Level I Review consists of an Inmate Death Review for the Division Chief attended by the following personnel, as soon as possible following the inmate death:

- Area Commander,
- Civil Litigation,
- Unit Commander of Medical Services,
- Chief Medical Physician,
- Quality Assurance Nurse,
- Concerned Facility Commander,
- Custody Support Services Lieutenant,
- Custody Support Services Staff conducting the Inmate Death Review,
- Custody Division Legal Advisor,
- Probation Department Representative (deceased inmate in a CBAC program only).

Most inmate deaths, attributed to natural causes, occurring in a hospital or medical facility, and deaths of inmates who are participating in a Community Based Alternative to Custody (CBAC) program, will qualify for a Level I Review.

The Level I Review requires that any action and/or task items identified during the review be assigned for follow-up. Issues discussed during the briefing, and documentation of the action and/or task items and assignments, shall be recorded in the Chief's memo and maintained in the review file. This will be the responsibility of the assigned Custody Support Services' Risk Analysis Deputy. If no issues are identified as a result of the review, the post-death review Chief's memo documenting the death review attendees, issues, etc., and attachments, shall comprise the file.

Level II Review and Reporting

A Level II Review is a more formal and detailed level of review and reporting than a Level I Review. A Level II Review consists of an Inmate Death Review attended by the following personnel, as soon as possible following the inmate death:

- Area Commander,
- Support Services Risk Management Commander,
- Concerned Custody Unit Commander,
- Homicide Bureau Lieutenant,
- Medical Services Unit Commander,
- Chief Medical Physician,
- Quality Assurance Nurse,
- Custody Support Services Lieutenant,
- Training Division-Custody Lieutenant,
- Custody Division Legal Advisor,
- Custody Support Services staff conducting the inmate death review,
- Representative from the Risk Management Bureau, Civil Litigation Unit,
- Representative from the Internal Affairs Bureau (if necessary),
- Representative from Jail Mental Health Services (deceased mental health inmates only),
- Division Chief, Court Services Division (deceased inmate in court lock up only),
- Division Chief, Field Operations Region (deceased inmate in field operations region station jail only),
- Station Commander (deceased inmate in field operations station only),
- Representative of the Probation Department (deceased inmate in a CBAC program only).

The Level II Review requires that any action and/or task items identified during the review be assigned for follow-up. Issues discussed during the death review, and documentation of the action and/or task items and assignments, shall be recorded and maintained in the review file. This will be the responsibility of the Custody Support Services' Risk Analysis Deputy.

Inmate deaths including suicides, homicides, and some natural cause inmate deaths with unusual or extenuating circumstances, shall generally require a Level II Review.

Level III Review and Reporting

A Level III Review is the highest level of Departmental review and reporting. A Level III Review shall involve an Executive Death Review as soon as possible following the inmate's death for Department executives, attended by the Sheriff, the Undersheriff, the Assistant Sheriffs, the Division Chief, and the following:

- Area Commander,
- Support Services Risk Management Commander,
- Department Risk Management Bureau Captain,
- Concerned Custody Unit Commander,
- Medical Services Unit Commander,
- Homicide Bureau Lieutenant,
- Internal Affairs Bureau Lieutenant,
- Risk Management Bureau - Civil Litigation Lieutenant,
- Custody Support Services Lieutenant,
- Training Division-Custody Lieutenant,
- Chief Medical Physician,
- Quality Assurance Nurse,
- Custody Division Legal Advisor,
- Advanced Training Bureau Sergeant,
- Custody Support Services staff conducting the inmate death review,
- Representative from Jail Mental Health Services (deceased mental health inmates only),
- Division Chief, Court Services Division (deceased inmate in court lock up only),
- Division Chief, Field Operations Region (deceased inmate in field operations region station jail only),
- Station Commander (deceased inmate in field operations station only).

The Level III Review requires that any action and/or task items identified during the review be assigned for follow-up. Issues discussed during the Executive Death Review, and documentation of the action and/or task items and assignments shall be recorded

and maintained in the review file. This will be the responsibility of the Custody Support Services' Risk Analysis Deputy.

Level III Reviews shall be conducted for all inmate deaths that occur at the hands of a deputy or other custody personnel, or as designated by the Division Chief.

Nothing in this policy shall preclude the level of review being changed to a different level, based upon additional facts, after an initial review.

Independent Risk Management Mortality Reviews

Following every in-custody inmate death, the Division Chief shall determine the need for an independent mortality review, conducted by a professional risk management organization, on contract with the Sheriff's Department's Risk Management Bureau. This decision will consider all of the facts surrounding an inmate's housing, treatment, and nature of any medical problems.

The independent risk management organization conducting the mortality review will be requested to provide a comprehensive review of the inmate death, within 4 to 6 weeks.

The review shall include areas of medical treatment, medications, and methodologies, as compared to current medical protocols. The review should also make recommendations for improvements or outline areas of failure in what would be considered a medically approved fashion.

Any request for an independent mortality review shall be directed to the Risk Management Bureau via memorandum by the unit commander of Medical Services, at the direction of the Division Chief.

Independent Risk Management Mortality Review Follow-up

The results of the independent mortality review shall be forwarded to Medical Services for review and follow-up. This review and any follow-up action shall be documented in a closure memorandum to the Division Chief. A copy of the closure memorandum and the Independent Risk Management Mortality Review report will be forwarded to Custody Support Services for retention in the in-custody inmate death review file.

Review of Coroner's Report by Medical Services

Representatives from Custody Support Services shall be responsible for ordering the coroner's report for review by the Division Chief. A copy of the report shall be forwarded to Medical Services for review by the Chief Physician.

U.S. Census Bureau:

Each quarter, Custody Support Services shall fill out for each death a "Local Jail Inmate Death Report" form. These forms shall be mailed to the U.S. Census Bureau each quarter. Any questions regarding this form should be directed to the Census Bureau.